TRAINING MODULE 7
STUDY PLAN

VA Medical Care

Objective:

To learn about health and medical care benefits available to veterans and eligible family members, and how to apply for and obtain such benefits.

References:

Title 38, U.S. Code, Chapter 17.

38 Code of Federal Regulations, Part 17.

Medical Manual M-1

VA Pamphlet 80-06-01, *Federal Benefits for Veterans and Dependents.*

Instructions:

Study the assigned reference materials to learn how to assist veterans, and eligible dependents and survivors, to apply for and obtain necessary medical care and services from VA medical facilities.

Summary:

UNDER THE VETERANS HEALTH ADMINISTRATION (VHA), THE DEPARTMENT OF Veterans Affairs (VA) operates one of the largest health-care delivery systems in the world. The system consists primarily of centralized comprehensive medical centers, most of which are affiliated with university medical schools, complemented and supplemented by an extensive network of outpatient clinics and readjustment counseling centers, as well as some nursing homes and domiciliaries.

In general, VA will provide health care, including medical or other treatment as required, to any honorably discharged veteran. VA will also furnish care to certain persons who received an other than honorable discharge from service, but only for a disability which was incurred in or aggravated by service, in line of duty [38 CFR §§ 3.360, 17.47(a)(2)]. Staffing and space permitting, VA medical facilities may furnish health care to certain veterans' dependents covered under CHAMPVA, as well as to military personnel and retirees and their families covered under TRICARE. VA will furnish needed care for problems related to spina bifida and certain other birth defects in eligible children of Vietnam veterans. Finally, VA medical facilities will furnish necessary emergency care, including hospital admission where required, on a humanitarian basis for *any* person regardless of status.

To obtain medical care, or health care benefits in general, it is necessary to apply for them. This is done by submitting a completed VA Form 10-10, *Application for Medical Benefits*, or 10-10ez, *Application for Health Benefits*, to the nearest VA medical facility. Except in emergency situations, a veteran seeking care for a service-connected condition will generally take precedence over others. In all other cases, the priority of care is as follows:

1. Veterans with service-connected ratings of 50% or more.
2. Veterans with service-connected ratings of 30% or 40%.
3. Veterans with service-connected ratings of 10% or 20%;
   Former prisoners of war;
   Veterans who were awarded the Purple Heart for combat wounds or injuries;
   Veterans who were discharged from service for service-connected disability; and
   Veterans who have special eligibility under 38 USC 1151.
4. Veterans determined by VA to be catastrophically disabled, or veterans entitled to receive special monthly pension (aid and attendance or housebound).
5. Veterans with no service-connected disabilities and veterans with 0% service-connected ratings, who are determined to be unable to defray the costs of needed care.
6. Veterans entitled to compensation for 0% service-connected disabilities (includes veterans entitled to the 10% rate based on multiple 0% disabilities under 38 CFR § 3.324, veterans entitled to special monthly compensation under 38 USC 1114(k) for loss or loss of use of a creative organ, and veterans entitled to special monthly compensation under the former 38 USC 1114(q) for arrested tuberculosis);
   Veterans who served during the Mexican Border Period and/or World War I; or
   Veterans seeking care solely for conditions claimed to be associated with exposure to ionizing radiation or toxic substances during service (including service in the Persian Gulf area) or for any illness associated with participation in tests conducted by the Department of Defense as part of Project 112 or Project SHAD.
7. Veterans with no service-connected disabilities and veterans with 0% service-connected ratings whose family income and assets meet statutory thresholds for "low-income," and who agree to make specified co-payments.
8. Veterans with no service-connected disabilities and veterans with 0% service-connected ratings whose income and net worth are greater than the above thresholds, and who agree to make specified co-payments.

To allow for planning and allocation of resources, all veterans applying to a VA medical facility for health care are required to enroll with VA, unless the veteran was discharged from service less than a year ago because of service-connected disability, even though VA has not yet rated it; or has a service-connected disability rated 50% or more; or is seeking treatment only for a service-connected disability. If budgetary resources require, enrollments may be deferred or discontinued for veterans in Priority Groups 7 and/or 8 on a year-by-year basis. On enrollment, the veteran will be assigned to one of the above priority groups, and is eligible for all needed inpatient and outpatient medical, surgical, and psychiatric services, including, but not limited to, drugs and pharmaceutical supplies, home healthcare, and hospice care. The veteran may choose a preferred facility for receiving primary care. The enrollment is for one year, and is automatically renewed each year unless the veteran requests that it not be renewed.

In general, a veteran must obtain health care from a VA medical facility, if reasonably available (usually considered as being within 30 miles of the veteran's residence). If the VA medical facility is unable to provide a needed service in a particular case, VA may either contract with local

facilities to provide the service or send the veteran (at VA expense) to the nearest VA medical facility that can provide the service. If no VA medical facility is reasonably available, VA may authorize the veteran to obtain specified care locally on a fee basis. If the veteran's service-connected disability is rated 50% or more, fee basis care may be authorized for any condition. If the service-connected rating is less than 50%, fee basis care may be authorized only for service-connected condition(s). Fee basis care must be authorized in advance in all cases.

If a veteran should require emergency treatment or admission to a non-VA medical facility for a service-connected condition, VA will reimburse the charges incurred provided the VA medical facility of jurisdiction is notified within 72 hours of such treatment or admission. VA will also reimburse cost of emergency treatment at a non-VA medical facility for a nonservice-connected condition, provided that:

- The veteran is currently enrolled in the VA Health Care system;
- The condition in question has been treated (by VA) within the previous two years; and
- The veteran is not covered under any other health services plan.

The only other circumstances under which VA will reimburse unauthorized expenses (emergency or otherwise) for a nonservice-connected condition are: if the veteran is rated permanently totally disabled from service-connected disabilities (whether 100% or by reason of individual unemployability), or if the veteran is enrolled in a program of Vocational Rehabilitation and it is medically determined that the treatment is required for the veteran to continue training. If VA agrees to reimbursement of unauthorized charges and the veteran requires prolonged hospitalization, VA will require transfer to a VA medical facility as soon as the veteran's condition permits.

VA will pay travel pay at common carrier rates for certain veterans to travel to and from a VA medical facility for the purpose of examination and/or treatment (including hospitalization) with a $3 deductible per trip, up to a maximum deductible of $18 per calendar month. Persons who qualify for travel pay include:

- Veterans seeking examination and/or treatment specifically of a service-connected condition, regardless of its percentage;
- Veterans who have a service-connected rating of 30% or more overall, for any condition;
- Veterans in receipt of VA pension, or whose income is below the statutory limits for VA pension and who are unable to defray the costs of travel;
- Veterans who have been scheduled for a Compensation and Pension (C & P) or other special purpose examination; and
- Veterans who require a specialized mode of transportation such as an ambulance, wheelchair van, etc., provided that:
    - A physician has determined that the veteran requires the specialized mode of transport;
    - The veteran is unable to defray the cost of the specialized transport, and
    - The travel has been authorized in advance.

Veterans who must travel to a C & P examination and veterans who require special modes of transportation are exempted from the deductible requirement; in other cases, the deductible may be waived on a showing that it would cause the veteran undue hardship. For veterans requiring specialized modes of transport, travel pay may also include the costs of meals and lodging en route, as well as the cost of an attendant. Prior travel authorization is required except in the event of a medical emergency or other circumstance where a delay would be hazardous.

Limited outpatient dental services are available at VA medical facilities. Veterans who are rated totally disabled from service-connected conditions (whether 100% or because of individual unemployability), former prisoners of war (with no distinctions based on length of captivity, beginning December 6, 2003), and veterans who have a service-connected dental disability of compensable severity are entitled to any and all necessary dental care. Veterans who are participating in a program of Vocational Rehabilitation are entitled to any dental treatment necessary for them to continue in their program. Veterans who suffered dental trauma in service, whether in combat or otherwise, are entitled to any necessary treatment for the specific (traumatized) teeth for which noncompensable service connection is established.

Other veterans with noncompensable service-connected dental disabilities are entitled to whatever treatment may be necessary for the one-time correction of the service-connected dental condition, provided they meet the length of service requirements and they make application to the Dental Clinic within 90 days after discharge from service. Veterans being treated for other conditions, whether as an inpatient or outpatient, may receive dental care which is medically necessary; that is, for a dental problem which is complicating the medical condition currently under treatment.

All VA medical facilities have special programs and services for female veterans. In addition to regular generic medical services, there is also a full array of gender-specific services for female veterans, such as gynecological (breast and pelvic) examinations and reproductive health care counseling. Preventive health care for female veterans includes contraceptive services, PAP smears, mammography, and menopause management. Counseling and therapy are also available for women who suffered sexual trauma during service. Some, but not all, VA medical facilities may offer maternity services. If a particular VA facility does not have a certain service available, it will either contract the service out or provide a community referral. There is a Women's Program Coordinator at each VA medical facility.

VHA provides extensive specialized rehabilitation services for severely disabled veterans. The Western Blind Rehabilitation Center is located at the VA Medical Center at Palo Alto, and provides extensive rehabilitation services for blind veterans throughout much of the state of California. There is another Blind Rehabilitation Center at the VA Medical Center in Phoenix, Arizona. Rehabilitative services from these centers are provided on an inpatient and outpatient basis, as well as through community-based organizations, for qualified blind veterans regardless of whether the blindness is service-connected. Members of the Visually Impaired Services Team (VIST) are assigned to many VA outpatient clinics for outreach purposes, and there are also VIS coordinators at all VA medical facilities. For veterans with diseases or injuries of the central nervous system, the VA Medical Centers at Long Beach and Palo Alto provide special rehabilitative services by the Brain Injury Unit and the Spinal Cord Injury Unit.

For veterans who are not acutely ill and do not require hospitalization, but who do require medium-to-long term custodial and/or skilled nursing care, VA has Nursing Home Care Units associated with some medical centers. Admission is on a space-available basis, with first priority given to veterans whose service-connected disability requires this level of care. Other veterans are considered in order of their priority groups.

If a veteran requires nursing home level of care and space is not available in a VA Nursing Home Care Unit, VA may place the veteran in a civilian nursing home under VA contract, as a VA beneficiary. A VA nursing home contract normally will not be for longer than six months, unless the condition requiring nursing home care is service-connected, or the veteran was hospitalized for a service-connected disability and then transferred to the nursing home. Under certain limited circumstances a veteran may be admitted directly to a civilian nursing home as a VA beneficiary.

Finally, VA may provide domiciliary care for veterans who are able to perform basic self-care tasks and require only low-level nursing, rehabilitation, and/or custodial services. Eligibility for admission to a domiciliary is income-based: the veteran's annual income may not be more than the maximum VA pension rate, or the veteran must be shown to have no adequate means of support. Only some VA Medical Centers offer domiciliary care; there are also VA domiciliaries which are not associated with a VA medical facility.

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Expiration Date: 6/30/2007

Department of Veterans Affairs — APPLICATION FOR HEALTH BENEFITS

SECTION GENERAL INFORMATION

Federal law provides criminal penalties, including fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false *statement. (See 18 U.S.C. I 001)*

1, VETERAN'S NAME *(Last, first, Middle Name)*	2 OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER
WILLIAMS, Lewis Payne	NONE	NORMAN	☒ MALE ☐ FEMALE

5 ARE YOU SPANISH, HISPANIC, OR LATINO?	6 WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only)*
☐ YES ☒ NO	☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☒ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7 SOCIAL SECURITY NUMBER	9 DATE OF BIRTH *(mm/dd/yyyy)*	10 RELIGION
237-74-9999	07/22/1947	PROTESTANT

8. CLAIM NUMBER	9A. PLACE OF BIRTH *(City and State)*
23 985 947-00	SAN FRANCISCO, CA

11 PERMANENT ADDRESS *(Street)*	11A. CITY	11B. STATE	11C ZIP CODE
17252 Jeanese Dr.	Angels Camp	CA	95111

11D. COUNTY	11 E. HOME TELEPHONE NUMBER *(Include area code)*	11F. E-MAIL ADDRESS
TUOLUMNE	(209) 555-1111	NONE

12 TYPE OF BENEFIT(S) APPLIED FOR *(You may), check more than one)*
☒ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL

13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?
PALO ALTO HEALTH CARE SYSTEM

14 DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE?	15 HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY?
☒ YES ☐ NO I am only enrolling in case I need care in the future.	☐ YES, LOCATION: _____ ☒ NO

16 CURRENT MARITAL STATUS *(Check one)*
☐ MARRIED ☒ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

17 NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	17A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
THELMA WILLIAMS (MOTHER) 17252 Jeanese Dr. Angels Camp, CA 95111	(209) 555-1212
	17B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*

18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
Lavonia Williams (Sister) 10946 Race Track Rd. Mt. Ranch, CA 95333	(209) 555-1212
	18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE *(Check One)*
☒ EMERGENCY CONTACT ☐ NEXT OF KIN

SECTION 11 - INSURANCE INFORMATION (Use a separate sheet for additional information)

1 ARE YOU COVERED BY HEALTH INSURANCE? *(Including coverage through a spouse or another person)* ☐ YES ☒	2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
3. NAME OF POLICY HOLDER N/A	
4 POLICY NUMBER / 5 GROUP CODE	

	YES	NO	
6. ARE YOU ELIGIBLE FOR MEDICAID?	☒	☐	
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	☐	☒	7A EFFECTIVE LA L *(mm/dd/yyyy)*
8, ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	☐	☒	8A. EFFECTIVE DATE *(mm/dd/yyyy)*

9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD	10. MEDICARE CLAIM NUMBER

11 IS NEED FOR CARE DUE TO ON THE JOB INJURY? *(Check One)* ☐ YES ☒ NO	12 IS NEED FOR CARE DUE TO ACCIDENT? *(Check One)* ☐ YES ☒ NO

VAFORM JUN 2004 **10-10EZ** PAGE 1

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME (Last, First, Middle)	SOCIAL SECURITY NUMBER
	WILLIAMS, Lewis Payne	237-74-9999

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS (check one) ☐ FULL TIME ☒ NOT EMPLOYED ☐ PART TIME ☐ RETIRED. If employed or retired, complete item 1A. Date of retirement (mm/dd/yyyy)	1A COMPANY NAME: N/A
2. SPOUSE'S EMPLOYMENT STATUS (check one) ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED. If employed or retired, complete item 2A. Date of retirement (mm/dd/yyyy)	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER: N/A

SECTION IV - MILITARY SERVICE INFORMATION

1 LAST BRANCH OF SERVICE	IA. LAST ENTRY DATE	1 B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1 D MILITARY SERVICE NUMBER
US NAVY	02/29/1964	02/28/1968	Honorable	777 01 22

2. CHECK YES OR NO	YES	NO		YES	NO
A ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☒	E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☒
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☒	F WERE YOU EXPOSED TO ENVIRONMENTAL CONTAMINANTS WHILE SERVING IN SW ASIA DURING THE GULF WAR?	☐	☒
C, DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☒	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☒	☐
C1, IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☒
D. DID YOU SERVE IN COMBAT AFTER 11/1 1/1998?	☐	☒	1. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☒
E WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☒	J DO YOU HAVE A SPINAL CORD INJURY?	☐	☒

SECTION V - FINANCIAL DISCLOSURE

You are not required to provide the financial eligibility information Sections VI through IX. law may require VA to consider your household financial situation to determine your eligibility for enrollment, and/or requirement to pay copayments for medical care, medications, long-term care and/or receive beneficiary travel benefits for care of your nonservice-connected conditions. Review the table in Step I of the instructions to see what benefits are based on your financial status and what sections you should complete. If you are a 0% service- connected noncompensable or nonservice-connected veteran (and are not an Ex-POW, WWI veteran, Purple Heart recipient or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA copayments for care of your nonservice-connected conditions to be eligible for enrollment. See Section X - Consent To Copayments.

☐ NO, I DO NOT WISH TO PROVIDE INFORMATION IN SECTIONS VI THROUGH IX. I understand that my financial information will not be used to determine my eligibility for VA health care benefits that apply to me. I am agreeing to pay the applicable VA copayments. Sign and date the application in Section X11.

☒ YES, I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO ESTABLISH MY ELIGIBILITY FOR CARE. Complete all sections below that apply to you with last calendar year's information Sign date the application Section X11

SECTION VI - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)

1. SPOUSE'S NAME (Last, First, Middle Name): N/A	2. CHILD'S NAME (Last, First, Middle ,Name)
1A SPOUSE's MAIDEN NAME	2A. CHILD's RELATIONSHIP TO YOU (Check one) ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter
1B. SPOUSE's SOCIAL SECURITY NUMBER	2B. CHILD's SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT (mm/dd/yyyy)
I C. SPOUSE's DATE OF BIRTH (mm/dd/yyyy) / 1 D. DATE OF MARRIAGE (mm/dd/yyyy)	2D. CHILD's DATE OF BIRTH (mm/dd/yyyy)
1 E. SPOUSE's ADDRESS AND TELEPHONE NUMBER (Street, City, State, ZIP)	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO 2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3 IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE $	2G EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (e. g. tuition, books, materials) $

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1 GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, bonuses, tips, etc.) EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$ NONE	$ N/A	$ N/A
2, NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$ NONE	$ N/A	$ N/A
3 LIST OTHER INCOME AMOUNTS (e.g. Social Security, compensation, pension interest, dividends). EXCLUDING WELFARE.	$ 16,608.00	$ N/A	$ N/A

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last First, Middle)*	SOCIAL SECURITY NUMBER
	WILLIAMS, Lewis Payne	237-74-9999

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, Health insurance, hospital and nursing home).*	$ 3,632.12
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (Also *enter spouse or child's information in Section VI)*	$ NONE
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$ NONE

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH (Use *a separate sheet for additional dependent.)*

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts. stocks anti bonds)*	$ 70.00	$ N/A	$ N/A
2 MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS, *(e.g., second homes and non -income producing property. Do not count your primary home.)*	$ NONE	$ NONE	$ NONE
3 VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. *Exclude household effects and family vehicles.*	$ NONE	$ NONE	$ NONE

SECTION X - CONSENT TO COPAYMENTS

If you are a 0% service-connected veteran and do not receive VA monetary benefits or a nonservice-connected veteran (and you are not an Ex-POW, Purple Heart Recipient, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your nonservice-connected conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayment as required by law.**

SECTION XI - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the foriii.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information that you put in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS APPLICATION FOR HEALTH BENEFITS. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE
Lewis Payne Williams	1-7-05

VAFORM JUN 2004 **10-10EZ**

PAGE 3

OBM Approved No. 2900-0091
Estimated Burden Ave. 24 min.
Expiration Date: 6/30/2007,

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Department of Veterans Affairs

HEALTH BENEFITS RENEWAL FORM

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1 VETERAN'S NAME *(Last, First, Middle Name)*	2 OTHER NAMES USED
RUTH, Helen	

3. GENDER	4 SOCIAL SECURITY NUMBER *(This is a mandatory field)*	5 DATE OF BIRTH *(mm/dd/yyyy)*
☐ MALE ☒ FEMALE	123-98-4321	11/15/1933

6 PERMANENT ADDRESS *(Street)*	6A, CITY	6B STATE	6C, ZIP
100 Duchess Drive	Sonora	CA	95300

6D COUNTY	6E HOME TELEPHONE NUMBER *(Include area code)*	6F. E-MAIL ADDRESS
TUOLUMNE	(209) 555-1212	NONE

6G CELLULAR TELEPHONE NUMBER *(Include area code)*	6H. PAGER NUMBER *(Include area code)*
NONE	NONE

7 CURRENT MARITAL STATUS *(Check one)*

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN

8. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	8A NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
Sister Ruth (Sister) 111 Duchess Dr. Sonora, CA 95300	(209) 555-1212
	8B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*
9. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	9A EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
Monica Mc Clain (Friend) 117 Duchess Dr. Sonora, CA 95300	(209) 555-1212
	9B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

10. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH
Note This does not constitute a will or transfer of title. *(Check one)* ☐ EMERGENCY CONTACT ☒ NEXT OF KIN

SECTION II -INSURANCE INFORMATION (Use separate sheet for additional information)

1 ~ ARE YOU COVERED BY HEALTH INSURANCE, INCLUDING COVERAGE THROUGH A SPOUSE OR ANOTHER PERSON? ☒ YES ☐ NO	2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER,
3 NAME OF POLICYHOLDER RUTH, Helen	Mutual of Omaha Mutual of Ohama Plaza Omaha, NE 68175

4. POLICY NUMBER	5 GROUP CODE	6. ARE YOU ELIGIBLE FOR MEDICAID?
M1111-LL-55-PP		☐ YES ☐ NO

7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	7A EFFECTIVE DATE *(mm/dd/yyyy)*
☒ YES ☐ NO	08/01/1997
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	8A EFFECTIVE DATE *(mm/dd/yyyy*
☒ YES ☐ NO	08/01/1997
9 NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD	10. MEDICARE CLAIM NUMBER
HELEN RUTH	123-98-4321-A

SECTION III - EMPLOYMENT INFORMATION

1 VETERANS EMPLOYMENT STATUS *(check one)*	ADDRESS AND TELEPHONE NUMBER
☐ FULL TIME ☒ NOT EMPLOYED *If employed or retired, complete item 1A* ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*	N/A
1 SPOUSE'S EMPLOYMENT STATUS *(check one)*	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
☐ FULL TIME ☐ NOT EMPLOYED *If employed or retired, complete item 1A* ☐ PART TIME ☐ RETIRED *Date of retirement (mm/dd/yyyy)*	N/A

SECTION IV - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 24 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1 710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program, VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

VA FORM **10-10EZR** NOV 2004 Supersedes VA Form 10-I0EZR, June 2004, which will not be used. PAGE I

Department of Veterans Affairs

VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER
RUTH, Helen	123-98-4321

SECTION V - FINANCIAL DISCLOSURE

Failure to disclose your previous year's financial information may affect your eligibility for health care benefits. Your financial information is used by VA to accurately determine if you should be responsible for copayments for office visits, pharmacy, inpatient, nursing home and long term care, and for some veterans, priority for enrollment. You are not required to provide this information. However, completing the financial disclosure section results in a more accurate determination of your eligibility for health care services/benefits.

☐ **NO**, I DO NOT WISH TO PROVIDE INFORMATION IN SECTIONS A THROUGH IX. ***I understand that VA is not currently enrolling veterans who decline to provide financial information unless other special eligibility factors exist.*** *However, if I am already enrolled, I agree to pay the applicable VA copayments. Sign and date the form in Section X1.*

☒ **YES**, I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO ESTABLISH MY ELIGIBILITY FOR CARE. *Complete all sections below that apply to you with last calender year's information. Sign and date the application Section XI.*

SECTION VI - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)

1 SPOUSES NAME *(Last, First, Middle Name)*: N/A	2. CHILD'S NAME *(Last, First, Middle Name)*: N/A
1A SPOUSE'S MAIDEN NAME	2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter
1 B SPOUSE'S SOCIAL SECURITY NUMBER	2B CHILD'S SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* / 1 D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
1 E SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*	2E WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO
	2F IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3, IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT — *SPOUSE $* / CHILD $	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $

SECTION VII PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(e.g. wages, bonuses , tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS.	$ NONE	$ N/A	$ N/A
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$ NONE	$ N/A	$ N/A
3 LIST OTHER INCOME AMOUNTS *(e.g.. Social Security, compensation, pension, interest, dividends).*	$ 12,321.00	$ N/A	$ N/A

SECTION VIII PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE LAST CALENDAR YEAR *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home)* VA will calculate a deductible and the net medical expenses you may claim.	$ 2,701.27
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$ NONE
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials)* DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	$ NONE

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD I
1. CASH, IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$ 28,400.00	$ N/A	$ N/A
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property* DO NOT INCLUDE YOUR PRIMARY HOME.	$ NONE	$ N/A	$ N/A
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. *Exclude household effects and family vehicles.*	$ NONE	$ N/A	$ N/A

SECTION CONSENT TO COPAYMENTS

If you are a 0% service-connected veteran and do not receive VA monetary benefits or a nonservice-connected veteran (and you are not an Ex-POW, Purple Heart Recipient, WWI veteran or *VA* pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only If you agree to pay VA copayments for treatment of your nonservice-connected conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayment as required by law.**

SECTION XI - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section I 72,), VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected *VA* medical care or services furnished or provided to me. I hereby authorize payment directly *VA* from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS ON WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE (mm/dd/yyyy)
Helen Ruth	1-7-05

VA FORM 10-10EZR NOV 2004 PAGE 2

OMB Number 2900-0219
Estimated burden 10 minutes
Expiration date: 3/31/2007

SAMPLE COPY

Department of Veterans Affairs

Application for CHAMPVA Benefits

VA Health Administration Center — CHAMPVA Eligibility — PO Box 469028 — Denver, CO 80246-9028 — 1 800.733.8387 — FAX 303.331.7809

Attention: After reviewing Page 2, complete form in its entirety (print or typewritten only) and return with a copy of the sponsor's DD214 (Report of Separation from Active Duty) along with other *required documentation.*

Section I - Sponsor Information

Veteran's Last Name	First Name	MI	Social Security Number	VA File Number (Claim Number)
KARNEY	Wilbert	H	252-34-1290	29 906 555-00

Street Address	City	State	Zip Code
501 Spring Lake Dr.	Twain Harte	CA	95300

Telephone Number (include area code)	Date of Birth (mm/dd/yyyy)	Is veteran military retired?	Is veteran deceased?	Date of Death (mm/dd/yyyy)	Did veteran die while on active military service?
(209) 555-1212	05/05/1948	☐ YES ☐ NO	☐ YES ☒ NO (If no, go to Section II		☐ YES ☐ NO

Section II - Applicant Information (if necessary continue additional 10-10 Od and complete in its entirety)

Last Name	First Name	MI	Social Security Number	Sex
KARNEY	Rosie	T	252-90-9999	☐ MALE ☒ FEMALE

Street Address	City	State	Zip Code
501 Spring Lake Dr	Twain Harte	CA	95300

Telephone Number (include area code)	Date of Birth	Children age 18 to 23 must provide certification of school enrollment (see Page 2).	Eligible for Medicare? If yes, attach copy of Medicare card.	Relationship to Veteran (i.e., spouse, child, stepchild)
(209) 555-1212	04/10/1952		☐ yes ☒ no	SPOUSE

Last Name	First Name	MI	Social Security Number	Sex
				☐ MALE ☐ FEMALE

Street Address	City	State	Zip Code

Telephone Number (include area code)	Date of Birth	Children age 18 to 23 must provide certification of school enrollment (see Page 2).	Eligible for Medicare? If yes, attach copy of Medicare card.	Relationship to Veteran (i.e., spouse, child, stepchild)
			☐ Yes ☐ No	

Last Name	First Name	MI	Social Security Number	Sex
				☐ MALE ☐ FEMALE

Street Address	City	State	Zip Code

Telephone Number (include area code)	Date of Birth	Children age 18 to 23 must provide certification of school enrollment (see Page 2).	Eligible for Medicare? If yes, attach copy of Medicare card.	Relationship to Veteran (i.e., spouse, child, stepchild)
			☐ Yes ☐ No	

Last Name	First Name	MI	Social Security Number	Sex
				☐ MALE ☐ FEMALE

Street Address	City	State	Zip Code

Telephone Number (include area code)	Date of Birth	Children age 18 to 23 must provide certification of school enrollment (see Page 2).	Eligible for Medicare? If yes, attach copy of Medicare card.	Relationship to Veteran (i.e., spouse, child, stepchild)
			☐ Yes ☐ No	

Section III - Certification

Federal Laws (1 8 USC 287 and 1 001) provide for criminal penalties for knowingly submitting or making false, fictitious, fraudulent statements

► *I certify that the above information is correct and true to the best of my knowledge and belief. (Sign and date on right,) If certification is signed by a person other than an applicant, complete the following.*

Signature	Date
Wilbert Karney	1-7-05

Last Name	First Name	MI	Telephone Number (include area code)	Relationship to Applicant(s)
KARNEY	Wilbert	H	(209) 555-1212	SPOUSE

Street Address	City	State	Zip Code
501 Spring Lake Dr	TWAIN HARTE	CA	95300

VA FORM MAR 2004 (R) 10-10d — Existing Stock of VA Form 10-10d, JUN 2001, will be used. — FRONT

SAMPLE COPY

OMB Number, 2900-0219
Est. burden: 10 minutes
Expiration Date: 3/31/2007

Department of Veterans Affairs

CHAMPVA Claim Form

VA Health Administration Center CHAMPVA **PO Box 65024** **Denver CO 80206-9024** **1.800.733.8387**

Attention: After reviewing the following, complete form in its entirety (print or typewritten only) and return with *required* **documentation.**

Claim form usage: This form is to be completed by the patient, sponsor, or guardian and is mandatory for all beneficiary claims. This claim form is NOT to be used for provider submitted claims.

Other health insurance (OHI): If OHI exists attach OHI's Explanation of Benefits (EOB) to the provider's itemized billing statement(s). Dates of service and provider charges on EOB must match billing statements.

Timely filing requirement: Claims must be received no later than one year after the date of service or, in the case of inpatient care, within one year of the discharge date.

Itemized billing statements: An itemized statement must be attached and contain:
- patient name, date of birth, and CHAMPVA Authorization Card (A-Card) number (same as patient's Social Security Number);
- provider name, degree, tax identification number (TIN), address and telephone number-, and
- service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e. CPT-4 HCPCS, and ICD-9-CM codes), including narrative descriptions. Pharmacy claims are to include name, quantity, strength, and NDC of each drug.

Section I - Patient Information

Last Name (This is a mandatory field.)	First Name (This is a mandatory field.)	MI	Social Security Number (This is a mandatory field.)
KARNEY	ROSIE	T	252-90-9999

Street Address ☐ check if new	Date of Birth (mm/dd/yyyy)
501 Spring Lake Dr.	04/10/1952

City	State	Zip Code	Telephone Number (include area code)
TWAIN HARTE	CA	95300	(209) 555-1212

Section II - Other Health Insurance (OHI) Information

By law, other coverage must be reported. Except for CHAMPVA supplemental policies. CHAMPVA is always the secondary payer. If more space is needed, please continue in the same format on a separate sheet.

Was treatment for a work-related injury or condition ☐ yes ☒ no

Was treatment for an injury or accident outside of work? ☐ yes ☒ no

Is patient covered by other primary health insurance to include coverage through a family member (supplemental or secondary insurance excluded)?

☐ yes (check type below and provide coverage information on the right)
- ☐ employer sponsored (group)
- ☐ private (non-group)
- ☐ Medicare (Part A or B)
- ☐ other (specify) _____

☒ no (proceed to Section III)

Name of Other Health Insurance OHI

OHI Policy Number | OHI Telephone Number (include area code)

Name of Other Health Insurance (OHI)

OHI Policy Number | OHI Telephone Number (include area code)

Section III - Sponsor Information

Last Name	First Name	MI	Social Security Number
KARNEY	WILBERT	H	252-34-1290

Section IV - Claimant Certification

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious, or fraudulent statements or claims.

Release of Medical Information. Signature in this section authorizes the patients providers to release medical record documentation related to the services associated with this claim I his consent pertains to all medical records including records related to treatment for psychological and psychiatric conditions, drug and alcohol abuse acquired immune deficiency syndrome human immunodeficiency virus infection, and sickle cell disease.

I certify that the above information and attachments represent actual services, dates, and fees charged. (Sign and date on right.) If certification is signed by a person other than the patient, complete the information the signature and date.

Signature: X Rosie Karney Date: 1-7-05

Last Name	First Name	MI	Relationship to Patient

Street Address

City	State	Zip Code	Telephone Number (include area code)

VA Form MAR 2004 (R) **10-7959a** EXISTING STOCK OF VA FORM 10-7959a, JUL 1999, WILL BE USED.

SAMPLE COPY

OMB Number 2900-0219
Estimated burden 10 minutes
Expiration date. 3/31/2007

Department of Veterans Affairs

CHAMPVA - Other Health Insurance (OHI) Certification

VA Health Administration Center | CHAMPVA | PO Box 65023 | Denver, CO 80206-9023 | 1 800 733.8387

Attention: After reviewing Page 2 complete form in its entirety (print or typewritten only) and return with a copy of the sponsor's DD214 (Report of Separation from Active Duty) along with other *required documentation*

Section I - Beneficiary information

Start with the sponsor's spouse and continue with all other CHAMPVA-eligible family members (regardless of OHI coverage). For each individual that had OHI coverage (excluding CHAMPVA) since becoming CHAMPVA eligible, be sure to complete the OHI information on the second and third line of each entry. If more than one HOI, continue on a separate sheet.

Spouse Information (if CHAMPVA-eligible)

Last Name	First Name	MI	Social Security Number	Have you had OHI since becoming CHAMPVA eligible?
KARNEY	Rosie	T	252-90-9999	☒ yes ☐ yes (go to Other Eligible Family Members' Information)

OHI Policy Name	OHI Policy Number	OHI Phone Number (include area code)
N/A	N/A	N/A

Start Date (mm/dd/yyyy)	Dates that OHI Covered Expiration Date (mm/dd/yyyy)	Is/was this a CHAMPVA-supplemental policy (see definition on Page 2?)	Is/was this an FEHB policy (see definition on Page 2?)
N/A	N/A	☐ yes ☐ no	☐ yes ☐ no

All Other CHAMPVA-Eligible Family Members' Information (if necessary, continue on additional 10-7959c and complete in its entirety)

Last Name	First Name	MI	Social Security Number	Have you had OHI since becoming CHAMPVA eligible?
				☐ yes ☐ yes (go to Other Eligible Family Members' Information)

OHI Policy Name	OHI Policy Number	OHI Phone Number (include area code)

Start Date (mm/dd/yyyy)	Dates that OHI Covered Expiration Date (mm/dd/yyyy)	Is/was this a CHAMPVA-supplemental policy (see definition on Page 2?)	Is/was this an FEHB policy (see definition on Page 2?)
		☐ yes ☐ no	☐ yes ☐ no

Last Name	First Name	MI	Social Security Number	Have you had OHI since becoming CHAMPVA eligible?
				☐ yes ☐ yes (go to Other Eligible Family Members' Information)

OHI Policy Name	OHI Policy Number	OHI Phone Number (include area code)

Start Date (mm/dd/yyyy)	Dates that OHI Covered Expiration Date (mm/dd/yyyy)	Is/was this a CHAMPVA-supplemental policy (see definition on Page 2?)	Is/was this an FEHB policy (see definition on Page 2?)
		☐ yes ☐ no	☐ yes ☐ no

Section II - Medicare Information

Are any individuals listed in Section I covered by:	1) First Name of Medicare-Eligible Beneficiary	Part A--Start Date (mm/dd/yyyy)	Part B--Start Date (mm/dd/yyyy	Medicare Card Number
1) Medicare Part A? ☐ yes ☐ no 2) Medicare Part B? ☐ yes ☐ no (If yes to either, attach copy of Medicare Card and complete this Section. If no to *both*, *go* to Section III.)				
	2) First Name of Medicare-Eligible Beneficiary	Part A--Start Date (mm/dd/yyyy)	Part B--Start Date (mm/dd/yyyy)	Medicare Card Number

Section III - Certification (to be completed by the beneficiary, sponsor, or legal guardian)

Federal Laws (18 USC 287 and 1001) provide for criminal penalties knowingly submitting making false fictitious or fraudulent statements or claims

I certify that the above information is correct to the best of my knowledge and belief. If there should be ANY change in OHI status for the above beneficiaries, I will promptly notify VA'S Health Administration Center. Sign and date on right, and complete the next two lines of information.

Signature: X Rosie Karney

Date: 1-7-05

Last Name	First Name	MI	Phone Number (include area code)	Relationship to Beneficiary(ies)
KARNEY	Rosie	T.	(209) 555-1212	SELF

Street Address ☐ check if new	City	State	Zip Code
501 Spring Lake Dr.	Twain Harte	CA	95300

VAFORM MAR 2004 (R) **10-7959c**

EXISTING STOCK OF VA FORM 10-7959C, JUN 2001, WILL BE USED.

FRONT

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OMB No.- 2900-0080
Estimated Burden 15 min.
Expiration Date. 11 30 2007

Department of Veterans Affairs

CLAIM FOR PAYMENT OF COST OF UNAUTHORIZED MEDICAL SERVICES

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 o the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38, United States Code. "Veterans Benefits," and will be used to assist us in determining your entitlement to reimbursement for services rendered. It will not be used for any other purpose. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your claim. Failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled.

PART I

1A. VETERAN'S NAME (Last, first, middle initial)	1B. CLAIM NUMBER	1C. SOCIAL SECURITY NUMBER
SUITE, GEORGE	C- 23 456 789-00	123-45-6789

1D. VETERAN'S ADDRESS (Include complete ZIP Code)

1 NOBLE LANE
SONORA, CA 95300

2A. NAME AND ADDRESS OF PERSON, FIRM OR INSTITUTION MAKING CLAIM (Leave blank if same as above)	2B. SOCIAL SECURITY NO. OR EMPLOYEE IDENTIFICATION NO.

3. STATEMENT OF CIRCUMSTANCES UNDER WHICH THE SERVICES WERE RENDERED (include diagnosis, symptoms, whether emergency existed, and reason VA facilities were not used)

I WAS TAKEN TO THE DOCTORS MEDICAL CENTER EMERGENCY ROOM IN MODESTO, CA ON 11/12/2004 FOR SEVERE CHEST PAINS, NAUSEA, SHORTNESS OF BREATH.
THE DIAGNOSIS WAS MI.
I WAS HOSPITALIZED FOR 7 DAYS, 4 OF THOSE DAYS I WAS IN ICU.
MY VA MEDICAL CENTER WAS CALLED BY THE STAFF OF DOCTORS MEDICAL CENTER AND THEY WERE TOLD NO BEDS WERE AVAILABLE.
NEAREST VAMC IS 100+ MILES AWAY.
THE TREATMENT WAS FOR MY SERVICE CONNECTED DISABILITY.

4. AMOUNT CLAIMED	
$ 8,962.38	Attach bills or receipts showing services furnished, dates and charges

5. COMPLETE A OR B AS APPROPRIATE

A. Amount charged does not exceed that charged the general public for similar services. Payment has not been received.	B. I certify that the amount claimed has been paid and reimbursement has not been received.
SIGNATURE AND TITLE OF PROVIDER OF SERVICE AND DATE	SIGNATURE OF VETERAN OR REPRESENTATIVE AND DATE 01-07-05

PART II - FOR VETERANS AFFAIRS USE ONLY

6. ACTION	CLAIM MEETS THE REQUIREMENTS OF VA REGULATION
☐ APPROVED $ _____ ☐ DISAPPROVED	☐ 6081 ☐ 6081

7. SIGNATURE OF CHIEF, MEDICAL ADMINISTRATION SERVICE	8. DATE	9. ADMINISTRATIVE VOUCHER NUMBER

VAFORM
MAY 2001 (R) **10-583**

— Notes —

Study Questions:

Using the assigned references and reading materials, answer the following questions:

1. Access to VA medical facilities is strictly limited to only veterans.
(T/F)

2. With certain exceptions, veterans who apply for health care from VA will be assigned to one of _____ groups to determine priority of routine care.

a. Four (4)

b. Six (6)

c. Eight (8)

d. Ten (10)

3. Which priority group is required to make a co-payment in order to receive health care from a VA medical facility?

4. If a VA medical facility is not reasonably available, veterans with service-connected disabilities may request to be treated by their own private physicians, at VA expense.
(T/F)

5. If a veteran requires emergency hospitalization at a non-VA facility for a service-connected condition, VA will reimburse the unauthorized costs of hospitalization, provided that:

a. VA is notified within 72 hours of admission.

b. The condition is rated at least 50% disabling.

c. The veteran certifies that he or she is unable to defray the cost of the care.

d. All of the above.

6. VA will reimburse the cost of unauthorized medical expenses for a nonservice-connected condition provided:

a. It was a medical emergency and the veteran is enrolled in the VA Health Care system.

b. The veteran is rated totally disabled by service-connected disability.

c. The veteran is training under Vocational Rehabilitation and the treatment is required for the veteran to be able to continue training.

d. Any of the above.

7. VA will authorize travel pay for certain veterans who must travel to a VA medical facility for examination or treatment. This travel pay is subject to a deductible provision, except for those veterans who:

a. Are required to report for a Compensation & Pension examination.

b. Are rated 30% or more for the service-connected condition being treated.

c. Are in receipt of VA nonservice-connected disability pension.

d. Are over age 65.

8. A former Prisoner of War is entitled to any and all necessary dental care by VA or at VA expense, regardless of the length of captivity.
(T/F)

9. Eligibility for blind rehabilitation services requires that the veteran's loss of vision be due to service-connected causes.
(T/F)

10. If VA places a veteran into a civilian nursing home under contract as a VA beneficiary, the usual length of the contract is

a. 90 days.

b. Six (6) months.

c. One year.

d. There is no time limit for the contract.